

FILLED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30957

Registration District No. 48

Primary Registration District No. 5072

Registrar's No.

1. PLACE OF DEATH: Bates

(a) County: Bates

(b) City or town: Rural Homer twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 007

(a) State: Missouri (b) County: Bates 0

(c) City or town: Rural Homer twp 0  
(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME: Annie Elizabeth Williams

(b) If veteran, name war: no

(c) Social Security No.: none

4. Sex: female

5. Color or race: white

6. (a) Single, widowed, married, divorced: 3 divorce

6. (b) Name of husband or wife: Lorin A. Williams

6. (c) Age of husband or wife if alive: 28 years

7. Birth date of deceased: May 15 1870  
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: Chalk Level 0 Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: House-wife

11. Industry or business: \_\_\_\_\_

MOTHER FATHER { 12. Name: Henry Schlickman

18. Birthplace: 4 Germany  
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Teekins

15. Birthplace: 4 Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Mack Bracken

(b) Address: Amoret Missouri

17. (a) Burial (b) Date thereof: 9-20-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mulberry Cemetery

18. (a) Signature of funeral director: Archer & Mongold

(b) Address: Amsterdam Mo.

19. (a) 9/20-1941 (b) Mrs Carl Hall  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18  
year 1941 hour 8 AM minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 18 1941 to Sept 18 1941; that I last saw her alive on Sept 16 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: No operations

Of operations: Some cancer glands removed

Of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_ X

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature: T. H. Halsey (M. D. or other) D

Address: Butler Mo Date signed: 9-19-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30957**  
Registrar's No. ....

Registration District No. **48**

Primary Registration District No. **5072**

1. PLACE OF DEATH:

(a) County **Bates**  
(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community **30 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Annie E. Williams**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **D**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **May 15 1872**  
(Month) (Day) (Year)

8. AGE: Years **71** Months **4** Days **3**  
(If less than one day, in min.)

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (City, town, or county) (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **11/2 1941** (b) **Mrs Carl Hall**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **18** year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him....., give on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer** Duration **1**  
**Had been removed about 1911. Later history glands removed about 1930. This was a surgical cancer - X-ray treated by Dr. Jackson. Due to cancer with reduced tobacco. Normal in 1930. Started began to bother her could not return food about this time. Other conditions: tumor in left lung, adenoma in colon. This was not seen until 36 hours since Crested Glands removed.**  
Major findings: **NO Operation with 36 hours since Crested Glands removed.**  
Of autopsy **none**  
**Hulsey**

**50**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **T. J.** (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1941

S-30957